



DEPARTMENT OF HEALTH
AND HOSPITALS



Patient Protection and Affordable Care Act (PL-148) (PPACA)
Health Care and Education Reconciliation Act (PL-152) (HCERA)
Together known as ***The Affordable Care Act (ACA)***

2,400 pages of statutory language

Thousands of pages of regulations

New federal and state organizations

In the midst of...

- New Governors
- New Congress
- Historic budgetary shortfalls
- A growing deficit
- Louisiana State Elections in 2011
- A Presidential Election in 2012



What has/will be implemented?

Insurance changes

- Children on family policies
- Rate review
- Rescission restrictions, out-of-pocket limits
- Medical Loss Ratio
- Essential Benefit Plans
- Health Benefit (Insurance) Exchanges

Medicaid changes

- Largest expansion in the history of the program
- Mandates for coverage and payment
- System requirements
- Requires primary care codes to be reimbursed at 100% of Medicare rates in 2013 and 2014
- Fraud and abuse

Medicare changes

- Prevention services – annual check-up
- Reduction in provider payments
- “Outcomes” or value based purchasing
- Fraud and abuse

Workforce Development Opportunities

- Focus on prevention, primary care, and underserved populations



ACA Opportunities for Workforce Development

- Several provisions aimed at improving public health outcomes and reducing costs through changes in the healthcare workforce.
- Strong focus on prevention and primary care as a means to tackling these dual concerns.
- Specific provisions to target poor and underserved populations.
- Some of programs are new, whereas others are extensions or expansions of existing programs.
- Some programs are “funded” by ACA, whereas others are only “authorized” and require funding by subsequent legislation.



Examples of ACA Workforce-Related Programs

- Teaching Health Center Grants: funds for “teaching health centers” for establishing or expanding primary care residency programs (allocated).
- Community Health Workforce: funds to promote positive health behaviors and outcomes for medically underserved communities through the use of community health workers (allocated).
- National Health Service Corps (NHSC): funding for NHSC, which will be used to recruit primary care providers to serve underserved areas and populations by reducing or eliminating student debt(allocated).
- Primary Care Loan Repayments: limits the time that individuals who receive certain federally supported student loans must practice in primary care to no more than ten years or such time the loan is repaid (previously had to remain in primary care until repayment without a maximum time limit).
- Primary Care Training and Enhancement: five-year grants to encourage primary care training for physicians and physician assistants(authorized).
- Preventive Medicine and Public Health Training funding: funds for entities to operate or participate in a residency or internship programs in preventive medicine or public health (authorized).
- Rural Physician Training: grants to medical schools for rural-focused training programs (authorized).

**Source: Abrams, M., R. Nuzum, S. Mika, and G. Lawlor. “Realizing Health Reform’s Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers.” The Commonwealth Fund. (January, 2011).*



Provider Enrollment and Screening

- Final rule issued on the ACA provisions regarding screening procedures of providers of medical or other services and supplies in Medicare, Medicaid, or CHIP.
- Screening measures for providers designated by level of risk for fraud, waste, and abuse at enrollment and re-validation every 5 years.
 - Provider types categorized by the HHS Secretary as either limited, moderate, or high risk
 - Physicians and other non-physician practitioners are considered “limited” risk
 - New screening measures for provider types which correspond with level of risk
 - Limited – enrollment requirements, license including out of State licensure checks and database verification (i.e. tax delinquency, SSN verification, OIG exclusion lists)
 - Moderate – all of the above plus unscheduled or unannounced site visits
 - High Risk - all of the above plus fingerprinting criminal history check
- **Effective March 25, 2011**
 - New providers subject to rule March 25, 2011
 - Existing providers subject to rule March 23, 2012
 - Comments on finger printing issue are due within 60 days of publication date (2/2/11)
 - www.regulations.gov (CMS Rule 6028)



Individual Mandate

Penalties and Exceptions

Penalties

- In 2014, the uninsured will be fined either \$95 or 1% of annual income, whichever is greater
- In 2015, the penalties increase to either \$325 or 2% of annual income
- In 2016 and beyond, the penalty is \$695 or 2.5% of annual income

Exemptions

- those who earn less than 100% of the federal poverty level
- “hardship” cases for whom insurance will cost more than 8% of their income
- illegal immigrant;
- prisoners
- religious objectors
- Indian tribe members
- those who are uninsured for less than three months of the year



Employer Mandate

- requires employers with more than 50 workers to provide federally dictated “minimum essential coverage,” or else pay a \$2,000 fine per worker, starting in 2014
- If an employer offers health insurance that does not provide “minimum essential coverage” and at least one worker qualifies for ACA’s new federal subsidies, the penalty can be as much as \$3,000 per worker.



American Health Benefit Exchanges (HBEs)

- Can be combined with the Small Business Health Care Options Program (SHOP) exchange
- Qualified Health Plans (Sec. 1301)
- ACA established four tiers of insurance plan offerings, based on the actuarial value (AV) of the plans in each tier. Minimum AVs for each tier are as follows: Bronze= 60%; Silver=70%; Gold=80%; Platinum=90%
- The HHS Secretary will determine, on or before January 1, 2013, whether a state has made sufficient progress towards establishment of an exchange.
- If the state does not choose to establish its own exchange, the Secretary will step in to establish the exchange directly, or appoint a non-profit entity to do so on behalf of the state.



HBE Costs & Credits for Individuals

- **Tax Credits:** Only those purchasing their insurance directly from the exchange (i.e.; not through an employer-sponsored plan) will be eligible for the credits and subsidies. The tax credits, which will flow directly to insurers on the individual's behalf, will be available to those earning between 133 percent to 400 percent of the Federal Poverty Level (FPL).
- **Cost of Premium:** Maximum is set on a sliding scale starting at 3 percent of “modified adjusted gross income” for those earning 133 percent FPL and increasing gradually to 9.5 percent for those between 300 percent to 400 percent FPL.
- **Maximum Out of Pocket:** Those under 200 percent of FPL would be limited to spending no more than 1/3 of the out-of-pocket maximum for all exchange plans. Those between 201 percent to 300 percent would pay no more than half. And those between 301 percent to 400 percent would pay no more than 2/3 of the maximum.

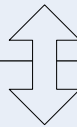


**Health Insurance Exchange
Health Benefit Exchange**

Private Pay

Premium Tax Credit/Assistance

Up to 400% FPL (\$43,320/individual)
Phased Out from 3% of income at
138% FPL to 9.5% of income at 400%
FPL



Medicaid

Up to 133% FPL, Actually 138% FPL
(\$14,400/Individual)



Web portal –
Allows all plans to participate, allows
individuals to compare plans and enroll



Highly Regulated, setting detailed rules
that insurers must meet in order to
participate



HEALTH CARE REFORM

State Challenges

1. How to research the Health Benefit Exchange opportunities and challenges in Louisiana with no defining regulations on the Health Benefit Insurance Exchange until at least Spring, 2011?
2. How to evaluate the Health Benefit Insurance Exchange with no defining regulations on the essential benefit package until at least Fall, 2011?
3. How to ensure the active involvement of appropriate Interest Groups?
4. How to ensure the least disruption with our Employer-based insurance market?
5. How to ensure the provider community is able to provide services to a large number of individuals who, before 2014, have never had insurance?
6. How to ensure that Medicaid and LaCHIP are able to provide services to the newly eligible recipients?
7. How to ensure that systems are put into place that protect the program from fraud and abuse?



Tax Related Changes in ACA

- New restrictions on some previously tax-free spending that uses Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), or Health Reimbursement Accounts (HRAs), generating \$1.4 billion in new revenue starting in 2011
- An increase in the penalty for early withdrawals from HSAs, generating \$1.4 billion in new federal revenue starting in 2011
- A new cap on total FSA spending, generating \$13 billion in new federal revenue starting in 2013
- An increase in the threshold for being able to deduct medical expenses on personal tax returns, from 7.5 percent of adjusted gross income, to 10 percent, generating \$15.2 billion in new revenue starting in 2013
- A new 3.8 percent tax on investment income for workers making more than \$250,000, generating \$123 billion in new federal revenue starting in 2013
- An excise tax on high-value health insurance, or “Cadillac,” plans, generating \$42 billion in new federal revenue starting in 2018.



New Taxes in ACA

- \$20 billion tax on medical device manufacturers
- \$22 billion tax on brand-name prescription drugs
- \$60 billion tax on large health insurers



Stakeholder Involvement

Issue Interests Groups

Interest Groups will be created around specific issues and interests. This will allow input from a larger group of individuals while ensuring that we receive critical expertise and advice.

These meetings will be conducted throughout the state.

The staff of the Office of Health Care Reform will gladly meet with any group regarding health care reform and its impact on Louisiana.



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